County of San Bernardino

DEPARTMENT OF BEHAVIORAL HEALTH
MENTAL HEALTH PLAN (MHP)

2005/2006
Quality Improvement Work Plan

Revised October 18, 2005

County of San Bernardino

DEPARTMENT OF BEHAVIORAL HEALTH
MENTAL HEALTH PLAN

Annual Quality Improvement Work Plan 2005/2006

The San Bernardino Mental Health Plan Quality Improvement Program is committed to insuring that the highest possible quality of mental health and recovery services are available to meet the needs of our culturally diverse and growing population.

The services provided by the Mental Health Plan should be accessible, timely; consumer and recovery focused and achieve positive outcomes for culturally diverse populations across all age groups.

The Annual Quality Improvement Work Plan is the annual planning and evaluation tool of the overall effectiveness of the Quality Improvement Program and is essential for insuring that quality improvement activities contribute to the meaningful improvement in clinical care and beneficiary services.

The San Bernardino Mental Health Plan Quality Improvement Work Plan reflects the collaborative efforts and participation of consumers, providers and clinical and administrative staff.

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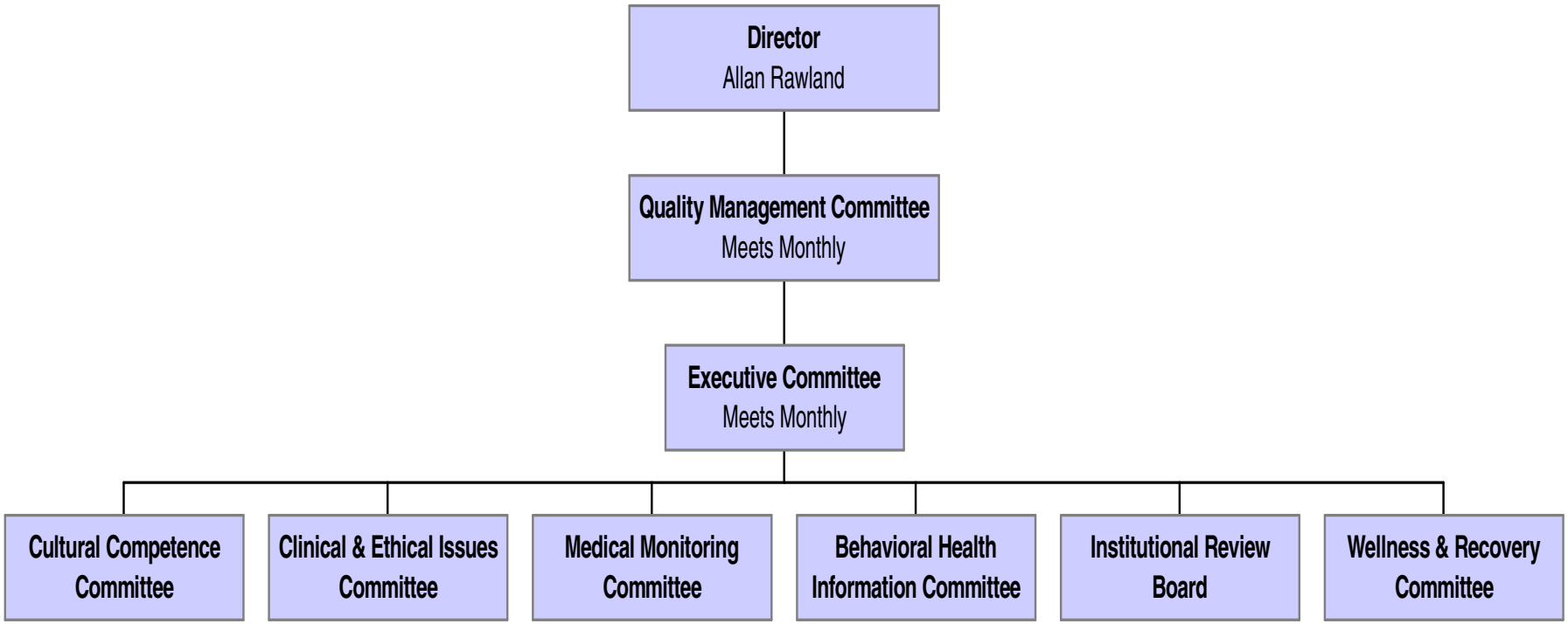
QUALITY IMPROVEMENT PROGRAM DESCRIPTION

The County of San Bernardino Mental Health Plan Quality Improvement Program Description outlines the structure and processes of the Quality Improvement Program with responsibility assigned to appropriate individuals. The following elements are included in the Quality Improvement Program Description:

- The Quality Improvement Program shall be evaluated and updated as necessary. The Quality Improvement Plan has been updated for Fiscal Year 2005/2006.
- The Quality Improvement Program is accountable to the MHP Director.
- Licensed Mental Health staff persons are substantially involved in the Quality Improvement Program implementation. The Quality Management Committees are chaired by Behavioral Health Professionals. (Attachment 1: Quality Improvement Program Committee organizational chart)
- The MHP's practitioners, providers, consumers and family members are active participants in the planning, design and execution of the QI Program. (Attachment 2: QI Committee memberships). The QI Plan by design has involved practitioners, providers, consumers and family members in all aspects of the QI Program.
- The role, structure, function and frequency of the meetings of the QI Committees are specified. (Attachment 1 and 3). The QM Committee oversees and is involved in QI activities, including performance improvement projects. The QM Committee recommends policy decisions; reviews and evaluates the results of QI activities including performance improvement projects; institutes needed QI actions; and ensures follow-up of the QI processes. QM Committee decisions and actions are documented in the dated and signed minutes.
- The QI Program coordinates with performance monitoring activities throughout the MHP, including, client and system outcomes, utilization management, credentialing, monitoring and resolution of the beneficiary grievances and fair hearings and provider appeals, assessment of the beneficiary and provider satisfaction, and clinical records review.
- Contracts with hospitals and with individual, group and organizational providers require cooperation with the MHP QI Program, and access to relevant clinical records to the extent permitted by State and Federal laws and the MHP and other relevant parties.

County of San Bernardino
Mental Health Plan
Quality Management Program Committees
FY 2005/2006



QUALITY MANAGEMENT PROGRAM
COMMITTEE FUNCTIONS

Quality Management Committee:

- Oversees the quality improvement program and quality management committees
- Reviews and evaluates the quality of care issues
- Reviews reports from quality management committees and recommends and institutes appropriate actions
- Recommends procedural and policy changes to improve the quality and delivery of mental health of services
- Presents issues and policy recommendations to MHP Director and Administration

Quality Management Executive Workgroup:

- Reviews, tracks and monitors the resolution of beneficiary grievances, state fair hearings, provider appeals, and inpatient and outpatient quality improvement referrals.
- Oversees and involved in QI activities, performance improvement projects, reviews and evaluates the results of QI activities.
- Institutes needed QI actions and ensures follow up of the QI processes.
- Coordinates with performance monitoring activities throughout the MHP.
- Identifies quality of care issues and forwards findings to Quality Management Committee

Cultural Competence Committee

- Assumes responsibility for coordinating trainings designed to enhance cultural competence.
- Conducts outreach activities to underserved and minority populations.
- Conducts focus groups to assess satisfaction and identify unmet behavioral health needs.
- Monitors the implementation of cultural competence plan goals.

Clinical & Ethical Issues Committee

- Anticipates and considers clinical aspects and implications of Departmental policies, procedures, and actions.
- Considers the ethical implications of Departmental and staff activities.
- Prepares reports of findings and recommendations for submission to the Quality Management Committee

Medication Monitoring Committee:

- Reviews and monitors the safety and effectiveness of medication practices.
- Reviews cases involving medication issues and tracks medication issues over time.
- Recommends and institutes needed actions involving medication procedures and policies
- Conducts peer reviews regarding medication practices

QUALITY MANAGEMENT PROGRAM
COMMITTEE FUNCTIONS – CONTINUED

Behavioral Health Information Committee

- Develops policies and procedures regarding the storage, retrieval and dissemination of behavioral health information (including the development of an electronic behavioral health record).
- Creates formats for new forms related to health information management.
- Disseminates procedures regarding the correct use of health information forms.

Institutional Review Board

- Reviews research proposals whenever human subjects are involved, or archived data related to human subjects are to be used.
- Assures the protection of the safety, rights and welfare of consumers.
- Receives research proposals that are generated both from within the Department and from graduate students at nearby universities.
- Reviews proposals to ensure they are found to meet standards of participant protection, are HIPAA compliant, are of potential value to the field, and have design integrity.
- Forwards proposals to the Director with recommendations that research be approved.
- Submits summary reports to the Department at the conclusion of the project.

Wellness & Recovery Committee

- Operationalizes the concepts of wellness and recovery in ways that can be implemented within the Department.
- Creates partnerships with entities that can carry out these operational plans (e.g., team houses, private industry).
- Sponsors and/or conducts research that assesses the effectiveness of programs with a wellness/recovery orientation.

QUALITY IMPROVEMENT PROGRAM COMMITTEE MEMBERSHIPS

QUALITY MANAGEMENT COMMITTEE

Chair:	Medical Director
Member:	Director
Member:	Assistant Director
Member:	Deputy Director - Adults
Member:	Deputy Director - ADS
Member:	Deputy Director – Administrative Services
Member:	Deputy Director – Children Services
Member:	Lead Child Psychiatrist
Member:	Program Manager – Quality Management
Member:	Cultural Competency Coordinator
Member:	Quality Improvement Coordinator
Member:	Quality Management Supervisor
Member:	Research & Evaluation Supervisor
Member	Medical Records Supervisor
Member:	Family Support Coordinator
Member:	Consumer
Member:	Consumer
Member:	Consumer
Recorder:	Secretary I

QUALITY MANAGEMENT EXECUTIVE WORKGROUP

Chair:	Quality Management Program Manager
Member:	Quality Improvement Coordinator
Member:	Cultural Competency Committee Chair
Member:	Institutional Review Board Chair
Member:	Clinical & Ethical Committee Chair
Member:	Medication Monitoring Committee Chair
Member:	Behavioral Health Information Committee Chair
Member:	Wellness & Recovery Committee Chair
Recorder:	Secretary I

CULTURAL COMPETENCE COMMITTEE

The membership of the Cultural Competence Committee will reflect diversity along a number of dimensions, including:

- Cultural/Ethnic Background
- Gender
- Age
- Experience as a mental health consumer
- Physical and/or sensory challenge
- Spiritual Practice
- Sexual Orientation
- Lifestyle Choice

Recorder

CLINICAL & ETHICAL ISSUES COMMITTEE

Chair:	Department Compliance Officer
Member:	Psychiatrist
Member:	Ph.D.
Member:	LSCW
Member:	MFT
Member:	R.N.
Member:	Case Manager
Member:	Consumer
Member:	Consumer
Recorder:	

QUALITY MANAGEMENT PROGRAM COMMITTEE MEMBERSHIPS

MEDICATION MONITORING COMMITTEE

Chair:	Medical Director
Member:	Lead Child Psychiatrist
Member:	Psychiatrist
Member:	Psychiatrist
Member:	Psychiatrist
Member:	Psychiatrist
Member:	Psychiatrist
Member:	Quality Improvement R.N
Member:	R.N.
Member:	Consumer
Recorder:	Secretary II

BEHAVIORAL HEALTH INFORMATION COMMITTEE

Chair:	Medical Records Supervisor
Member:	Psychiatrist
Member:	Clinical Therapist I
Member:	R.N.
Member:	Information Technology Staff Member
Member:	Case Manager
Member:	Clerical Supervisor
Member:	Consumer
Member:	Clerk
Recorder:	Secretary I

INSTITUTIONAL REVIEW BOARD

Chair:	Research & Evaluation Supervisor
Member:	Ph.D.
Member:	Ph.D.
Member:	Ph.D.
Member:	Psychiatrist
Member:	LCSW
Member:	Consumer
Recorder:	

WELLNESS & RECOVERY COMMITTEE

Chair:	Clinic Supervisor
Member:	Clinical Therapist
Member:	Clinical Therapist
Member:	Case Manager
Member:	Case Manager
Member:	Consumer
Member:	Consumer
Member:	Consumer
Member:	Consumer
Recorder:	

QUALITY IMPROVEMENT ACTIVITY #1
SERVICE CAPACITY OF THE MENTAL HEALTH PLAN (MHP)

ACTIVITY 1-1	DISTRIBUTION OF MENTAL HEALTH SERVICES.
Source:	MHP contract with the State Department of Mental Health.
Objective:	Describe the current number, types and geographic distribution of mental health services within the MHP's delivery system.
Purpose:	To develop a quantified statement of the MHP's service delivery capacity.
Planned Activities/ Monitoring:	Update the narrative and quantified descriptions of the MHP's service delivery system at least annually or whenever major structural or functional changes occur
Data:	Numbers of client contact hours available for all clinical staff at each service delivery location multiplied by the productivity proportion of 65%. Use of the Clinical Activity Report (CAR) and Staff Activity Report (SAR)
Data Source:	Clinic Supervisors and Program Managers
Analysis of Data:	For each service delivery location, the number of client contact hours available for a typical month will be calculated. These "service capacity" measures will be summed across all Department of Behavioral Health (DBH) clinics within a given region to yield a regional service capacity index. The Regional service capacity index for the four regions will then be summed to yield a monthly service capacity index for the entire MHP.
Office Responsible for Data Analysis & Monitoring:	Quality Management Division – Office of Research & Evaluation
Report to:	Cultural Competence Committee

ACTIVITY 1-2	GEOGRAPHIC DISTRIBUTION OF MEDI-CAL BENEFICIARIES
Source:	MHP Contract with the State Department of Mental Health
Objective:	To determine the geographic distribution of Medi-Cal beneficiaries in the DBH regions.
Purpose:	To obtain one indicator of potential demand for behavioral health services in each region at least once annually.
Planned Activities/ Monitoring:	Update this indicator of potential demand for behavioral health service in each region at least once annually
Data:	Number of Medi-Cal eligible individuals by zip code from the Department of Health Services
Data Source:	Department of Health Services
Analysis of Data:	Develop geographic definitions of the DBH regions in terms of zip codes. The number of Medi-Cal beneficiaries in the constituent zip codes of each DBH region can then be summed to yield a total regional population.
Office Responsible for Data Analysis & Monitoring:	Quality Management Division – Office of Research & Evaluation
Report to:	Cultural Competence Committee

QUALITY IMPROVEMENT ACTIVITY #2
MONITORING THE ACCESSIBILITY OF SERVICES

ACTIVITY 2-1	AFTER-HOURS AVAILABILITY OF MENTAL HEALTH SERVICES
Source:	MHP contract with State Department of Mental Health
Objective:	All DBH clinics and contract agencies will have after-hours telephone messages (or answering machines) which will provide information in English and Spanish for beneficiaries on how to access both emergency and routine mental health services.
Purpose:	To make it possible for all beneficiaries to learn how to access mental health services after regular business hours and on weekends by telephoning clinic or contract agency sites.
Planned Activities/ Monitoring:	DBH clinic supervisors will monitor their clinics' answering machines on a monthly basis, and will forward reports to their program managers and to the Quality Management Division. In addition, Quality Management Division staff will make random test calls every six months to each DBH clinic either before or after normal business hours to determine whether the required message or answering service response is present. Results of these test calls will be forwarded to program managers, with a copy to the Office of the Director.
Data:	Number of DBH clinic which have the required after-hours message or which have answering services which have the required information.
Data Source:	Number of DBH clinic supervisor and program managers.
Analysis of Data:	A simple count of the number of clinics which are and are not in compliance.
Office Responsible for Data Analysis & Monitoring:	Clinic Supervisors and Program Managers
Report to:	Cultural Competence Committee

ACTIVITY 2-2	INCREASE THE NUMBER OF BILINGUAL MHP STAFF
Source:	APS External Quality Review, January 10-11, 2005 and data generated internally by DBH.
Objective:	Increase the number of Spanish speaking clinical staff in each region by at least two (2) during the 2005-2006 fiscal year.
Purpose:	Increase MHP linguistic service capacity
Planned Activities/ Monitoring:	Linguistic abilities of newly hired clinic staff during the 2005-2006 fiscal year will be monitored by region. In addition, advertisements will be placed in professional journals to broaden the scope of the MHP's customary outreach.
Data:	Language abilities of newly hired Clinical Therapists, Social Worker IIs, and Case Managers.
Data Source:	DBH Payroll Department
Analysis of Data:	A simple frequency count of the number of Spanish speaking clinicians hired in each region during the 2005-2006 fiscal year.
Office Responsible for Data Analysis & Monitoring:	Clinic Supervisors and Program Managers
Report to:	Cultural Competence Committee

QUALITY IMPROVEMENT ACTIVITY #2 - CONTINUED
MONITORING THE ACCESSIBILITY OF SERVICES

ACTIVITY 2-3	INCOMPLETE DATA ON INITIAL CONTACT LOGS (ICLs)
Source:	Plan of Correction in Response to the January 12-16, 2004 Medi-Cal Oversight Review
Objective:	Initial Contact Logs (ICLs) will contain all required data elements.
Purpose:	To ensure compliance with Title 9 regulations
Planned Activities/ Monitoring:	A Department-wide training will be done to ensure that staff is fully trained in completing the ICL accurately and consistently in accordance with Title 9 regulations. All ICLs not on the electronic database, will be sent to the Quality Management Division each month and will be reviewed and monitored for compliance with Title 9 regulations. Incomplete logs and logs not in compliance will be identified and technical assistance will be provided to sites and staff to correct deficiencies. The After-hours ICL will be reviewed each business day.
Data:	All required data elements for initial requests for Medi-Cal services: • Date and time • Whether request is urgent • Name of caller • Name of beneficiary (if different) • Whether interpreter services were offered • Caller's response to the offer of interpreter services • Reason for the call • The initial disposition • The response time to obtain services • The name of the staff member completing the entry.
Data Source:	ICLs
Analysis of Data:	1. Frequency count of the number of requests for service that were urgent and a frequency count of the number of requests for service that were routine. 2. For urgent requests, how many and what percentage of urgent requests were responded to within two (2) hours. 3. For routine requests, how many and what percentage of total routine requests were responded to within 14 days. 4. How many requests for interpreter services were received. 5. Did requests for interpreter services tend to be associated with longer response times.
Office Responsible for Data Analysis & Monitoring:	Clinic Supervisors will review ICLs on a monthly basis and submit a report to the Quality Improvement Coordinator, Quality Management Division, who will be responsible for summarizing this data and identifying problem areas.
Report to:	Cultural Competence Committee

QUALITY IMPROVEMENT ACTIVITY #2 - CONTINUED
MONITORING THE ACCESSIBILITY OF SERVICES

ACTIVITY 2-4	MHP FEE-FOR-SERVICE PROVIDER LISTS DID NOT INCLUDE MENTION OF CULTURAL SERVICES. NO LIST OF DBH (I.E. NON-CONTRACT) PROVIDERS THAT INCLUDED ALTERNATIVES AND OPTIONS FOR CULTURAL/LINGUISTIC SERVICES WAS AVAILABLE
Source:	Plan of Correction in response to January 12-16, 2004 Medi-Cal Oversight Review.
Objective:	To include alternatives and options for cultural services on the MHP's Fee-for-Service (FFS) provider list and to develop a list of DBH (i.e. non-contract) providers that includes alternatives and options for cultural/linguistic services.
Purpose:	To comply with Medi-Cal requirements for availability of provider lists.
Planned Activities/ Monitoring:	The MHP has revised its FFS provider list to include alternatives and options for cultural services. All MHP sites will have an available list of their own non-contract providers that includes alternatives and options for cultural/linguistic services. MHP staff will be trained on the requirements regarding the availability of these lists and a review of beneficiary rights as stated in the *Consumer Guide* and in regulations.
Data:	Provider lists.
Data Source:	1. ACCESS Unit for FFS providers 2. DBH clinics and contract agencies for all other staff lists.
Analysis of Data:	Not applicable
Office Responsible for Data Analysis & Monitoring:	1. ACCESS Unit Clinic Supervisor for the FFS provider lists 2. Office of Research & Evaluation for all other staff lists.
Report to:	Cultural Competence Committee

QUALITY IMPROVEMENT ACTIVITY #2 - CONTINUED
MONITORING THE ACCESSIBILITY OF SERVICES

ACTIVITY 2-5	SERVICE ACCESSIBILITY FOR CULTURALLY/LINGUISTICALLY DIVERSE POPULATIONS
Source:	Plan of Correction in response to the January 12-16, 2004 Medi-Cal Oversight Review
Objective:	Determine the number of service hours provided to non-English speaking clients in each region where: 1. The service was provided by a monolingual English therapist or physician and interpreter services were provided by a second DBH employee. 2. The services were provided by a monolingual English therapist or physician and interpreter service was provided by an outside agency (e.g., AT&T, Simply Said). 3. The clinical and interpreter services were provided by the same clinician or physician.
Purpose:	To determine the baseline need for additional clinical staff that is proficient in a second language.
Planned Activities/ Monitoring:	The numbers of hours of service provided in the three categories defined in "Objective" above will be calculated by clerical staff at each of the outpatient clinics and contract agencies by using codes recently added to the Charge Data Invoice (CDI) Forms.
Data:	Numbers of hours of service provided in the three categories defined in "Objective" above.
Data Source:	CDI forms. Different procedure codes differentiate the different service functions.
Analysis of Data:	Clerical staff should calculate the number of hours in each of the three service "categories" on a daily, weekly and monthly basis.
Office Responsible for Data Analysis & Monitoring:	Clinic Supervisors and Program Managers
Report to:	Cultural Competence Committee

QUALITY IMPROVEMENT ACTIVITY #3
MONITORING BENEFICIARY SATISFACTION

ACTIVITY 3-1	OBTAINING SURVEY FEEDBACK FROM BENEFICARIES AND FAMILY MEMBERS
Source:	MHP contract with State Department of Mental Health
Objective:	To obtain feedback from beneficiaries and their family members regarding the quality of services provided by the MHP as well as to gather suggestions for improvement.
Purpose:	To collect information which will make it possible for the MHP to address service deficiencies and to implement suggestions for improvement whenever feasible.
Planned Activities/ Monitoring:	1. The MHP conducts consumer surveys once each fiscal year to assess satisfaction with the services delivered and the manner in which they are delivered. 2. The results of the twice-yearly state Performance Outcome Surveys are also used to assess beneficiary satisfaction.
Data:	Responses to survey questions and ratings.
Data Source:	Results of MHP consumer surveys and state Performance Outcome Surveys.
Analysis of Data:	Analysis of survey data will be both quantitative (revealing for example, the percentages of respondents expressing certain points of view or assigning a particular rating) and qualitative (identifying those issues which beneficiaries mentioned as either problematic or positive).
Office Responsible for Data Analysis & Monitoring:	Quality Management Division – Office of Research & Evaluation.
Report to:	Clinical & Ethical Issues Committee

QUALITY IMPROVEMENT ACTIVITY #3 - CONTINUED
MONITORING BENEFICIARY SATISFACTION

ACTIVITY 3-2	OBTAINING FEEDBACK VIA FOCUS GROUPS FROM BENEFICIARIES AND FAMILY MEMEBERS
Source:	MHP contract with the State Department of Mental Health
Objective:	To obtain feedback from beneficiaries and their family members regarding the quality of services provided by the MHP, as well as to gather suggestions for improvement.
Purpose:	To collect information which will make it possible for the MHP to address service deficiencies and to implement suggestions for improvement whenever feasible.
Planned Activities/ Monitoring:	The MHP will conduct focus groups twice a year of each fiscal year with consumers and their family members. Groups will be held separately for various types of consumers based upon demographics or need for specialized information or services.
Data:	Comments made during focus groups regarding consumers and family members' feelings and attitudes regarding the MHP's mental health services and its service delivery system.
Data Source:	Focus groups
Analysis of Data:	Limited to qualitative analysis
Office Responsible for Data Analysis & Monitoring:	Regional Program Managers and Clinic Supervisor will assume responsibility for arranging the twice-yearly focus group meetings. Regional Program Managers will submit reports on the issues discussed to the Quality Management Division, which will review them in order to identify trends across the Department.
Report to:	Clinical & Ethical Issues Committee

QUALITY IMPROVEMENT ACTIVITY #3 - CONTINUED
MONITORING BENEFICIARY SATISFACTION

ACTIVITY 3-3	ANALYSIS OF GRIEVANCES, APPEALS & STATE FAIR HEARINGS
Source:	MHP contract with State Department of Mental Health
Objective:	To determine each fiscal year the number of grievances and State Fair Hearings which were filed or requested by beneficiaries, and to describe the nature of these grievances. Data for the current year will be compared with the data from the previous three (3) years in order to identify and understand any trends that may emerge.
Purpose:	To be able to identify and then address areas of beneficiary dissatisfaction.
Planned Activities/ Monitoring:	1. The ACCESS Unit will maintain information on all grievances filed and State Fair Hearings requested. Grievances will be coded in such a way that they can be assigned to appropriate content categories for tabulation. At the close of each fiscal year, the ACCESS Unit Grievance Coordinator will prepare an analysis of the grievances and State Fair Hearings filed during that year, together with a trend analysis which shows changes over the previous three- year period. 2. Any beneficiary grievance that involves a quality of care issue is identified by the ACCESS Unit Grievance Coordinator so that it can be reviewed by the Quality Management Executive Workgroup and, if necessary, receive expedited handling. 3. Based upon the information provided by the ACCESS Unit's Grievance Coordinator, the Quality Management Executive Workgroup identifies systemic quality of care issues, including but not limited to barriers to access, problems with providers, delay in receiving services, and denial of services. Issues in need of remedial action are forwarded by the Quality Management Executive Workgroup to the Program Manager II of the Quality Management Division, and are summarized for review by the Quality Management Committee.
Data:	Qualitative and quantitative information regarding beneficiary grievances and requests for State Fair Hearings.
Data Source:	Qualitative and quantitative data are derived from individual grievances files and from the computerized Continuous Quality Improvement (CQI) database.
Analysis of Data:	Grievances and requests for State Fair Hearings are described qualitatively in the CQI computerized database. In addition, a report is extracted annually from the computerized database that shows the numbers of grievances and State Fair hearings requests received, as well as the content categories into which each grievance or request falls. Data from the current fiscal year are compared to data from previous years in order to detect any trends that may exist.
Office Responsible for Data Analysis & Monitoring:	Quality Management Division – ACCESS Unit.
Report to:	Clinical & Ethical Issues Committee

QUALITY IMPROVEMENT ACTIVITY #4
MONITORING THE MHP'S SERVICE DELIVERY SYSTEM AND MEANINGFUL CLINICAL ISSUES AFFECTING BENEFICARIES, INCLUDING THE STAETY AND EFFECTIVENESS OF MEDICATOIN PRACTICES

ACTIVITY 4-1	MONITORING THE "DASHBOARD"
Source:	MHP contract with the State Department of Mental Health
Objective:	Identify issues which affect the quality of care provided to beneficiaries, and implement appropriate remedial measures either at the individual or system level.
Purpose:	Have an organized, systematic method for identifying issues that negatively affect the MHP's service delivery system or the quality of care that is provided.
Planned Activities/ Monitoring:	Certain variables within the MHP are monitored routinely. These include: • Initial Contact Logs to assess the timeliness with which requests for routine and urgent services are answered • Number and nature of grievances filed • Number of State Fair Hearings requested • Number of NOAs issued • Number of Request for Change of Provider forms received and the providers named in those requests • Number and nature of fee-for-service provider appeals received • Presence of after-hours telephone messages/answering services at DBH clinic and contract agency sites • Outpatient audits • Referrals by inpatient chart reviewers • Outlier identification reports from the Office of Research and Evaluation
Data:	See individual measures above.
Data Source:	Initial Contact Logs are either monitored electronically or are submitted to the Quality Management Division in paper form. Information regarding grievances and State Fair Hearings is provided by the MHP's ACCESS Unit. The numbers of NOAs issued, and information about the numbers of Change of Provider Requests received and acted upon is submitted monthly by outpatient clinics to the Quality Improvement Coordinator. Information regarding FFS provider appeals are supplied quarterly to the Quality Improvement Coordinator by the ACCESS Unit. Information regarding after-hours telephone messages/answering services is obtained from test calls.
Analysis of Data:	Quantitative analysis of these data is limited to frequency counts and examination for trends. Qualitative analysis is performed on grievances, State Fair Hearing requests, and FFS provider appeals.
Office Responsible for Data Analysis & Monitoring:	Frequency counts and qualitative summaries are prepared by the outpatient clinics and by the ACCESS Unit, and are forwarded to the Quality Improvement Coordinator for review.
Report to:	Clinical and Ethical Issues Committee.

QUALITY IMPROVEMENT ACTIVITY #4 - CONTINUED
MONITORING THE MHP'S SERVICE DELIVERY SYSTEM AND MEANINGFUL CLINICAL ISSUES AFFECTING BENEFICARIES, INCLUDING THE STAETY AND EFFECTIVENESS OF MEDICATOIN PRACTICES

ACTIVITY 4-2	SAFETY OF MEDICATION PRACTICES
Source:	MHP contract with the State Department of Mental Health
Objective:	To obtain information regarding the safety and effectiveness of medication practices.
Purpose:	To ensure the safety and effectiveness of medication practices, and to implement appropriate interventions when instances of poor quality of care have been identified.
Planned Activities/ Monitoring:	1. Physician peer review regarding medication practices. 2. Inpatient chart reviews by Inpatient Authorization Unit staff. 3. Staff review of grievances that concern dissatisfaction with medication strategies or practices. 4. Staff reviews of FFS physicians' authorization requests and medication declarations
Data:	Data for this activity consist of descriptions of concerns regarding medication practices. These concerns could include choice of drug, dosage, frequency of administration, nature and/or extent of work-up prior to prescribing, and adequacy of assessment for side effects.
Data Source:	Physician peer review, Inpatient Authorization Unit staff referrals, beneficiary grievances, and ACCESS Unit Mental Health Nurse II.
Analysis of Data:	The Medication Monitoring Committee performs qualitative analyses of data related to medication prescribing practices.
Office Responsible for Data Analysis & Monitoring:	Four sources provide information for this activity: Office of the Medical Director, Inpatient Authorization Unit, the ACCESS Unit's Grievance Coordinator, and the ACCESS Unit's Mental Health Nurse II.
Report to:	Medication Monitoring Committee

QUALITY IMPROVEMENT ACTIVITY #4 - CONTINUED

MONITORING THE MHP'S SERVICE DELIVERY SYSTEM AND MEANINGFUL CLINICAL ISSUES AFFECTING BENEFICARIES, INCLUDING THE STAETY AND EFFECTIVENESS OF MEDICATOIN PRACTICES

ACTIVITY 4-3	DOCUMENTATION FAILURE TO ADDRESS CLIENT PLAN CONDITION
Source:	Plan of Correction in Response to the April 11-15, 2005 EPSDT Audit
Objective:	To reduce the frequency with which documentation fails to address at least one of the conditions listed on the Client Plan which: 1. Result from a qualifying mental disorder and 2. Can be corrected or ameliorated by specialty mental health services to below 5% of charts sampled during internal audits.
Purpose:	To increase the MHP's degree of compliance with Medi-Cal documentation requirements.
Planned Activities/ Monitoring:	Clinic supervisors or their designees will review chart documentation to ensure that all claimed interventions address at least one of the conditions listed on the Client Plan which: 1. Result from a qualifying mental disorder and 2. Can be corrected or ameliorated by specialty mental health services. Data will be compiled on each clinician that indicates in what percentage of instances documentation requirements have not been met. For those clinicians whose documentation fails to meet requirements 5% or more of the time, individual remedial training will be provided by the clinic supervisor or his/her designee. Both the documentation deficiencies and the responses to the remedial training will be reflected in employees' Work Performance Evaluations (WPEs). Quality Management Division staff will offer "training for the trainers" to applicable clinic supervisors and/or their designees on topics related to the plan of correction. This will assist clinic supervisors in developing individualized on-site training and peer review programs. Program managers will monitor the outpatient clinics' compliance with this plan of correction.
Data:	Frequency counts of the number of charts for each clinician found to be out of compliance with this requirement.
Data Source:	Chart audits by Program managers, Clinic Supervisors and designees.
Analysis of Data:	Compute percentages of charts (for each clinician and for the clinic as a whole) in which deficiencies were encountered.
Office Responsible for Data Analysis & Monitoring:	Clinic Supervisors will be responsible for audits within their clinics; program managers will be responsible for monitoring the compliance of the outpatient clinics within their regions. Quality Management staff will be responsible for conducting the necessary training sessions.
Report to:	Clinical & Ethical Issues Committee.

QUALITY IMPROVEMENT ACTIVITY #4 - CONTINUED

MONITORING THE MHP'S SERVICE DELIVERY SYSTEM AND MEANINGFUL CLINICAL ISSUES AFFECTING BENEFICARIES, INCLUDING THE STAETY AND EFFECTIVENESS OF MEDICATOIN PRACTICES

ACTIVITY 4-4	ENSURE DOCUMENTATION OF CLIENT PARTICIPATION IN TREATMENT PLANNING
Source:	Plan of Correction in Response to the April 11-l 15, 2005 EPSDT Audit
Objective:	To ensure that all client plans contain documentation of the client's degree of participation and agreement with the client plan as evidenced by: 1. For long-term clients, the client's signature on the plan or an explanation of why the signature could not be obtained; or 2. For clients who are not long-term consumers, there should be reference to the client's participation and agreement to the plan within the body of the plan, the client's signature on the plan itself, or a description of the client's participation and agreement in the progress notes.
Purpose:	To ensure the clients are actively participating in their treatment plans and to ensure the MHP's compliance with Medi-Cal documentation requirements.
Planned Activities/ Monitoring:	1. Quarterly documentation training is offered to department and contracts staff, and FFS providers. 2. Training sessions will be conducted at each of the MHP's outpatient clinics, during which the need to obtain client signatures as a means of documenting client participation in the development of the Client Plan will be underscored. 3. Clinical staff will be responsible for reviewing all open charts of clients under their care to ensure that either a client signature is present on each Client Plan, or there is documentation explaining the client's refusal to sign.
Data:	Frequency counts for each clinician, and for each outpatient clinic or contract agency, of the number of Client Plans that do not contain client signatures or documentation explaining the client's refusal to sign.
Data Source:	Chart audits by clinic supervisors and designees.
Analysis of Data:	Tabulation of frequency counts of numbers of charts that do not contain required documentation elements for each clinician, as well as for the outpatient clinic/contract agency as a whole.
Office Responsible for Data Analysis & Monitoring:	Clinic Supervisors ,Program Managers and Deputy Directors.
Report to:	Clinical & Ethical Issues Committee.

QUALITY IMPROVEMENT ACTIVITY #4 - CONTINUED

MONITORING THE MHP'S SERVICE DELIVERY SYSTEM AND MEANINGFUL CLINICAL ISSUES AFFECTING BENEFICARIES, INCLUDING THE STAETY AND EFFECTIVENESS OF MEDICATOIN PRACTICES

ACTIVITY 4-5	ENSURE PROPER SIGNATURES ON ALL PROGRESS NOTES
Source:	Plan of Correction in Response to the April 11-15, 2005 EPSDT Audit
Objective:	To ensure that all progress notes include the signature of the staff providing the services, together with professional degree, license or job title.
Purpose:	To ensure compliance with Medi-Cal documentation requirements.
Planned Activities/ Monitoring:	It will be required that, when clinicians turn in their CDIs covering clinical services rendered, the originals (or copies) of the chart notes documenting the services accompany them. The clerical staff member responsible for entering CDI information will also be responsible for ensuring that each entry contains the required signature of the staff member(s) providing the claimed services, together with the professional degree, license or job title. The clerk will also maintain a log of the number of times each staff member fails to meet this signature requirement. This information will be forwarded to the clinic supervisor on a weekly basis for appropriate remedial action and for inclusion in the staff member's next Work Performance Evaluation (WPE).
Data:	Frequency counts of the numbers of times staff signatures are missing from progress notes.
Data Source:	Clerical reports to Clinic Supervisors following inspection of progress notes accompanying CDIs.
Analysis of Data:	Simple weekly tabulations of frequency count for each clinician and for the clinic/contract agency as a whole.
Office Responsible for Data Analysis & Monitoring:	Clinic Supervisors, Program Managers and Deputy Directors.
Report to:	Clinical & Ethical Issues Committee.

QUALITY IMPROVEMENT ACTIVITY #4 - CONTINUED

MONITORING THE MHP'S SERVICE DELIVERY SYSTEM AND MEANINGFUL CLINICAL ISSUES AFFECTING BENEFICARIES, INCLUDING THE STAETY AND EFFECTIVENESS OF MEDICATOIN PRACTICES

ACTIVITY 4-6	PROGRESS NOTES MUST ACCOMPANY CDIs
Source:	Plan of Correction in Response to the April 11-15, 2005 EPSDT Audit
Objective:	To ensure that progress notes exist for all billed claims.
Purpose:	To guarantee compliance with Medi-Cal documentation requirements for billed claims.
Planned Activities/ Monitoring:	It will be required that, when clinicians turn in their CDIs covering clinical services rendered, the originals (or copies) of the chart notes documenting the services accompany them. The clerk will keep a log of the number of times each staff member fails to submit a progress note to substantiate a claim on a CDI. This information will be forwarded to the Clinic Supervisor on a weekly basis for appropriate remedial action and for inclusion in the staff member's next Work Performance Evaluation (WPE).
Data:	Frequency counts of the numbers of times chart notes do not accompany CDIs for each clinician.
Data Source:	Clerical reports to clinic supervisors following inspection of progress notes accompanying CDIs.
Analysis of Data:	Simple weekly tabulations of frequency count for each clinician and for the clinic/contract agency as a whole.
Office Responsible for Data Analysis & Monitoring:	Clinic Supervisors and Program Managers.
Report to:	Clinical & Ethical Issues Committee.

QUALITY IMPROVEMENT ACTIVITY #4 - CONTINUED

MONITORING THE MHP'S SERVICE DELIVERY SYSTEM AND MEANINGFUL CLINICAL ISSUES AFFECTING BENEFICARIES, INCLUDING THE STAETY AND EFFECTIVENESS OF MEDICATOIN PRACTICES

ACTIVITY 4-7	POSTING OF MATERIALS REGARDING GRIEVANCE RESOLUTION PROCESS
Source:	Plan of Correction in Response to the January 12-16, 2004 Medi-Cal Oversight Review
Objective:	To have notices posted at all MHP provider sites explaining the grievance resolution process and procedures.
Purpose:	To ensure compliance with Title 9 requirements regarding the posting of beneficiary protection materials.
Planned Activities/ Monitoring:	The MHP will monitor the posting and availability of required beneficiary protection materials on a continuing basis, and quarterly monitoring reports will be submitted to the Quality Management Committee by the Office of Patients' Rights for ARMC—BH monitoring, and by Centralized Hospital Aftercare for FFS contract hospital monitoring. In addition, MHP provider sites will be monitored formally once a year when the Quality Improvement reviewers conduct annual audits of clinics, contractors and fee-for-service providers; the results of this monitoring are documented in the monitoring reports for the various sites.
Data:	Data indicating whether information regarding the grievance resolution process and procedures was present as required at ARMC and the various FFS hospitals with which the MHP has contracts.
Data Source:	Quarterly reports from the Office of Patients' Rights and the Centralized Aftercare Service.
Analysis of Data:	Analysis of data will consist of describing trends in compliance for each hospital being monitored, as well as group data on compliance for each reporting period.
Office Responsible for Data Analysis & Monitoring:	Office of Patients' Rights and Centralized Hospital Aftercare Services.
Report to:	Clinical & Ethical Issues Committee.

QUALITY IMPROVEMENT ACTIVITY #4 - CONTINUED
MONITORING THE MHP'S SERVICE DELIVERY SYSTEM AND MEANINGFUL CLINICAL ISSUES AFFECTING BENEFICARIES, INCLUDING THE STAETY AND EFFECTIVENESS OF MEDICATOIN PRACTICES

ACTIVITY 4-8	AVAILABILITY OF GRIEVANCE FORMS AND SELF-ADDRESSED ENVELOPES
Source:	Plan of Correction in Response to the January 12-16, 2004 Medi-Cal Oversight Review
Objective:	To have grievance forms and envelopes addressed to the MHP's ACCESS Unit available at all MHP provider sites.
Purpose:	To ensure compliance with Title 9 requirements regarding availability of beneficiary protection materials.
Planned Activities/ Monitoring:	The Patients' Rights Office will assume responsibility for monitoring ARMC as well as fee-for-service hospitals with which the MHP has contracts to determine whether grievance forms and envelopes addressed to the MHP's ACCESS Unit are available to beneficiaries without having to making a request. The Patients' Rights Office will submit a quarterly report to the Quality Management Committee.
Data:	Data indicating whether grievance forms and envelops addressed to the MHP's ACCESS Unit were present as required at ARMC and the various fee-for-service hospitals with which the MHP has contracts.
Data Source:	Quarterly reports from the Office of Patients' Rights.
Analysis of Data:	Analysis of data will consist of describing trends in compliance for each hospital being monitored, as well as group data on compliance for each reporting period.
Office Responsible for Data Analysis & Monitoring:	Office of Patients' Rights.
Report to:	Clinical & Ethical Issues Committee.

QUALITY IMPROVEMENT ACTIVITY #5
CONTINUITY AND COORDINATION OF CARE WITH PHYSICLA HEALTHCARE PROVIDERS AND OTHER HUMAN SERVICE AGENCIES

ACTIVITY 5-1	COORDINATION BETWEEN MHP AND PHYSICAL HEALTHCARE AGENCIES
Source:	MHP contract with the State Department of Mental Health
Objective:	Monitor nature and extent of coordination of services between the MHP and physical healthcare providers and other agencies used by the MHP's beneficiaries.
Purpose:	To ensure that physical and behavioral healthcare services are provided in a coordinated manner to the MHP's beneficiaries.
Planned Activities/ Monitoring:	1. The MHP will hold quarterly meetings with IEHP. 2. The MHP will hold quarterly meetings with Molina Healthcare. 3. Review and refine memoranda of understanding with both physical healthcare plans to reflect any procedural modifications. 4. Review the process for providing referrals from the MHP to IEHP and Molina. 5. Review the MHP's process for receiving referrals from IEHP and Molina. 6. Review the minutes of MHP and physical healthcare plan meetings for evidence of coordination of effort. 7. Review the processes for providing clinical (including medication) consultation and training among the three managed care entities (MHP, IEHP, Molina). 8. Review procedures for the exchange of medical record information between MHP and the physical healthcare plans. 9. Review the procedures for resolving disputes between the MHP and the two Medi-Cal managed care plans, including procedures for insuring that beneficiaries receive medically necessary services while disputes are being resolved.
Data:	Memoranda of understanding, minutes and procedures described above under "Planned Activities/Monitoring."
Data Source:	Memoranda of understanding, minutes and procedures described above under "Planned Activities/Monitoring."
Analysis of Data:	Qualitative
Office Responsible for Data Analysis & Monitoring:	Quality Management Division – ACCESS Unit.
Report to:	Clinical & Ethical Issues Committee.

QUALITY IMPROVEMENT ACTIVITY #6
PROVIDER APPEALS

ACTIVITY 6-1	RESOLVING PROVIDER CONCERNS AND APPEALS
Source:	MHP contract with the State Department of Mental Health
Objective:	To provide an effective means of identifying, resolving and preventing the recurrence of providers' problems with the MHP's authorization and other processes.
Purpose:	To ensure that providers' concerns and dissatisfactions are heard and, whenever possible, resolved quickly and expeditiously.
Planned Activities/ Monitoring:	1. Monitor the number, type and resolution of provider appeals. 2. Monitor whether provider appeals are being resolved within mandated time limits. 3. Monitor the adequacy of procedures designed to inform providers of the appeal process.
Data:	1. The number and nature of appeals filed by providers, as well as the nature of the resolution for each appeal. 2. Policies and procedures for notifying providers of the appeal process.
Data Source:	Provider Appeals Log
Analysis of Data:	Qualitative
Office Responsible for Data Analysis & Monitoring:	Quality Management Division – ACCESS Unit/ Provider Relations Representative
Report to:	Clinical & Ethical Issues Committee.

QUALITY IMPROVEMENT ACTIVITY #7
THERAPEUTIC BEHAVIORAL SERVICES (TBS): ACCESS, UTILIZATION RATES AND OUTCOMES

ACTIVITY	TBS ACTIVITY MONITORING
Source:	MHP contract with the State Department of Mental Health
Objective:	To monitor TBS access, utilization rates and outcomes.
Purpose:	To ensure ease of access, optimal levels of utilization, and clinically effective outcomes for children and youth who meet class membership criteria.
Planned Activities/ Monitoring:	1. Monitor TBS training and education activities. 2. Conduct a study of TBS access and utilization rates for class members. 3. Identify any trends related to TBS access, utilization rates, and consumer outcomes. 4. Assess client and family/caregiver satisfaction related to TBS access, service quality, and outcomes. 5. Review community outreach activities that target MHP beneficiaries and family members, including outreach activities designed for non-English-speaking individuals. 6. Conduct a review of the utilization of TBS services in the major geographical areas served by the MHP. 7. Review any grievances received by the MHP regarding access to TBS or satisfaction with TBS services. 8. Review any concerns expressed regarding TBS services by TBS providers.
Data:	1. Types and frequency of planned training and educational activities. 2. Information regarding TBS access, utilization rates and trends. 3. Results of client and family/caregiver satisfaction surveys. 4. Information regarding community outreach activities regarding TBS availability. 5. Information regarding grievances received regarding TBS services.
Data Source:	Management Information System (SIMON), TBS staff and the ACCESS Unit.
Analysis of Data:	Data from all of the above sources will be analyzed in an MHP system review of TBS activities. The review will begin by examining the adequacy of outreach efforts, and will then proceed to an assessment of access issues, utilization rates, outcome variables, and beneficiary/family member/caregiver satisfaction. Specific questions will include: • Do outreach activities appear adequate? Or does there appear to be disproportionate access for certain subgroups? • Are utilization rates similar for different consumer groups? For example, are certain age groups or ethnic groups disproportionately represented? Do those consumers who are receiving TBS services appear to establish eligibility by meeting one class membership criterion significantly more often than others? • What is the typical outcome? Do the TBS services enable consumers to remain at a lower level of care? Do the TBS services provided enable the consumer to move to a less restrictive level of care? • What do beneficiaries and family members/care givers say about the TBS services that were provided?
Office Responsible for Data Analysis & Monitoring:	Children's System of Care and the Quality Management Division's Office of Research & Evaluation
Report to:	Clinical & Ethical Issues Committee.

QUALITY IMPROVEMENT ACTIVITY #8
CULTURAL COMPETENCE ISSUES

ACTIVITY 8-1	IDENTIFYING MENTAL HEALTH NEEDS PROMINENT IN SPECIFIC CULTURAL GROUPS
Source:	MHP's Cultural Competency Plan
Objective:	Identify mental health service needs that are specific to one or more cultural groups within the MHP.
Purpose:	To be able to identify needs which are unique to a particular cultural/ethnic group, or which are more pronounced in a particular group, so that appropriate interventions can be designed to address these needs.
Planned Activities/ Monitoring:	Conduct focus groups targeted to a specific cultural/ethnic group.
Data:	Comments made during group meetings regarding consumers' and family members' feelings and attitudes regarding the MHP's mental health services and its delivery system, as well as input from cultural competence experts.
Data Source:	Focus Groups
Analysis of Data:	Limited to qualitative analysis.
Office Responsible for Data Analysis & Monitoring:	Quality Management Division – Office of Quality Improvement
Report to:	Cultural Competence Committee

PERFORMANCE IMPROVEMENT PROJECT PROPOSAL
Decrease Waiting Time for Initial Child Psychiatric Appointments

Summary

Problem: Families and staff have complained that at two primary outpatient DBH sites the average wait time for child psychiatry services routinely exceeds 14 working days.

Goal: Reduce delay from date of referral to first psychiatric appointment to 14 working days or less.

Sites involved: East Valley Resource Center and Upland, two major child psychiatry providers.

Data to be collected: Number of days between referral and initial child psychiatry assessment.

Initial data collection period: February 2005 through January 2006.

Planned interventions: Adjustment of staffing; improvements in system efficiency, establish a triage system that will prioritize which cases need to be seen right away and which can wait for an MD referral.

Post-intervention data collection period: October 2005 through March 2006.

[Note: Headers are as on NCQA Quality Improvement Activity Form]

Section I

A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.

The standard at San Bernardino County DBH is that an appointment for a psychiatric evaluation should be scheduled within two weeks of a request or referral for such an assessment. Recent reports suggest that wait times for initial child psychiatric appointments currently exceed six weeks at some department sites. In addition, the findings of a survey conducted in the summer and fall of 2004 included a concern voiced by both staff and clients that wait times for psychiatric appointments are excessive.

Studies looking for relationships between wait time and factors such as attrition in mental health systems have had mixed outcomes (*e.g.*, Lester, 1970; Rock, 1982; Gondolf & Foster, 1991; Anderson, Hogg, & Magoon, 1987; Frace, Weddington, & Houpt, 1978; Slaikeu, Lester, & Tulkin, 1973; Deane, 1991; Joshi et al., 1986), and a recent study (Sparks, Daniels & Johnson, 2003) concluded that wait times were not statistically significant in predicting no-shows for assessment appointments.

However, client satisfaction is an important system indicator, and both clients and behavioral health providers desire shorter wait times for needed mental health services. San Bernardino's MHP sets 14 workdays as the maximum amount of time that we will permit once a referral is made. According to SAMHSA (2005), "An important aspect of access to treatment is to provide timely initial appointments once individuals request services. About three-quarters of all products [providers] report having formal standards for maximum wait time from request for treatment to initial appointment."

This PIP will reduce waiting times for initial child psychiatry appointments by measuring the extent of the problem and providing data that can be used to adjust staffing at sites that provide child services, reduce no-shows, and establish meaningful referral criteria to ensure those most in need of psychiatric appointments are given priority for available appointments.

B. Quantifiable Measures. List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.

Quantifiable Measure #1:

Numerator:	Number of child referrals within the survey period that receive scheduled psychiatric appointments within 14 days.
Denominator:	Total number of child referrals for psychiatric appointments within the survey period.
First measurement period dates:	January 2005 through June 2005
Benchmark:	All minors referred for psychiatry assessments will receive appointments within 14 days, as per SBC-DBH Policy.
Source of goal:	12 months of data collection (February 2005 through January 2006)
Improvement goal:	Decrease wait times by 25% from Measurement Period 1 to Measure Period 2

C. Baseline Methodology. Include here information on how the benchmark was derived as well as the benchmark rate. NCQA defines "benchmark" as the industry measure of best performance against which the organization's performance is compared. It should be directly comparable to your QI measure. You may describe the benchmark in numerical terms (e.g., the 90th percentile), or in terms of the comparison group (e.g., the best published rate in our state, 85 percent). The benchmark may be best practice in the industry based on published data or the best performance within a corporation with multiple plans. NCQA requires a benchmark or a goal, but not both. Many service activities do not have benchmarks. If you are not using a benchmark, insert "NA" (not applicable) in response to this query.

DBH policy and the MHP establish the expectation that all referrals for new psychiatric appointments will receive scheduled appointments that are within 14 days of the referral.

1. Data Sources

- Medication referral log kept at local service sites.
- InSyst 'Clients and Episodes' Tables

2. Data Collection Methodology

The following procedures will be implemented at participating sites for the duration of the data collection periods:

At the time a referral is made for a child to be assessed by a psychiatrist, the staff at the referring site will record in an on-site log (1) the reporting unit number of the site, (2) the child's chart number and last name, (3) the date of referral, (4) the name of the referring staff person, (5) the date and time of the scheduled appointment, and (6) the name of the psychiatrist to which the child is being referred. (This log will be secured according to HIPAA guidelines.)

3. Sampling. (If sampling was used, provide the following information.)

Not applicable**;** all referrals for initial child psychiatry appointments at the selected sites will be recorded and used in the analysis.

4. Data Collection Cycle, Data Analysis Cycle.

a. Referral data will be recorded at the two target sites for six months beginning in January 2005, and used to establish the percentage of appointments provided within the required two-week period. These data elements will include:

- The reporting unit number of the site;
- The child's chart number and last name;
- The date of referral;
- The name of the referring staff person;
- The date and time of the scheduled appointment; and
- The name of the psychiatrist to which the child is being referred.

b. During the intervention phase, the program managers over child service units will implement appropriate changes, such as reassignment of staff, improvements in efficiency, and specification of referral criteria.

c. The results of a second six-month data collection period will be used to determine if these changes have produced the desired reductions in mean wait times.

Bibliography and References

Anderson, T.R., Hogg, J.A., & Magoon, T.M. (1987). Length of time on a waiting list and attrition after intake. *Journal of Counseling Psychology, 34*, 93-95.

Deane, F. (1991). Improving attendance at intakes in children's outpatient services of a community mental health center. *Child: Care, Health and Development, 17*, 115-121.

Frace, R.D., Weddington, W.W., & Houpt,S.L. (1978). Referral of patients from primary care physicians to a community mental health center. *Journal of Nervous and Mental Disease*, *166,* 594-598.

Gondolf, E.W., & Foster, R.A. (1991). Pre-program attrition in batterer programs. *Journal of Family Violence, 6*, 337-349.

Joshi.P.K., Maisami, M., & Coyle, J.T. (1986). Prospective study of intake procedures in a child psychiatry clinic. *Journal of Clinical Psychiatry, 47*, 111-113.

Rock, D.L. (1982). Appointments for intake interviews: An analysis of appointment-keeping behavior at an urban community mental heath center. *Psychological Reports, 50*, 863-868.

Slaikeu, K., Lester, D., & Tulkin, S.R. (1973). Show versus no show: A comparison of referral calls to a suicide prevention and crisis center. *Journal of Consulting and Clinical Psychology, 40*, 481-486.

Sparks, W.A., Daniels, J.A., & Johnson, E. (2003). Relationship of referral source, race, and wait time on preintake attrition. *Professional Psychology: Research and Practice, 34*, 514-518.

The Provision of Mental Health Services in Managed Care Organizations. SAMHSA. Accessed on 11 January 2005 at http://www. mentalhealth.samhsa.gov/publications/ allpubs/sma03-3797/content07.asp.

Walter, L.J., Parthasarathy, S., Allen, S., & Ackerson, L. (2002). Medicaid Patients in a Private Health Maintenance Organization: Patterns of Chemical Dependency Treatment. *Journal of Behavioral Health Services & Research*, 29(1).

PERFORMANCE IMPROVEMENT PROJECT PROPOSAL
Medication Dispensing Errors By Pharmacies

Summary

Problem: Over the past few years, the Department of Behavioral Health has identified occasional errors in the dispensing of medication to Department clients by pharmacies. Two types of errors were found: 1) clients were dispensed an incorrect dosage of medication, and 2) clients were dispensed the wrong medication. This could impact the care to any Department client who receives prescribed medications. Safety is impacted if a client receives incorrect medication(s), either through unanticipated side effects or more serious somatic reactions, including the possibility of death. In order for adjunctive psychotherapeutic treatments to be as efficacious as possible, the medications must be at a certain level, so incorrectly dispensed medications could make it impossible to conduct effective therapy. For several reasons, dispensing errors could therefore result in slower recovery from psychiatric problems.

Over the past two years, the Department's Medications Monitoring Committee (MMC) was made aware through anecdotal evidence that a number of errors had been detected with regard to medications dispensed by pharmacies, which did not match the medications prescribed by our Department M.D.s. No system for tracking errors in the dispensing of medications from pharmacies had been in place at the department, so an R.N. was given the task of coordinating the tracking of these errors for the Department, and reporting these to the MMC on a quarterly basis. The results of this tracking showed that an average of two errors were detected every three months, although this was probably an underreporting of the actual amount, since only those cases would show up in which the client informed the M.D. or nurse. To date no data has been systematically and comprehensively collected from which to establish a baseline for this problem. The Department Director of Medical Services has been sending a letter to the pharmacy involved in each incident, inquiring as to why the error occurred and urging them to be more careful.

Study Question

How often are dispensing errors made, and can they be reduced?

Goal: To identify errors in pharmacies' dispensing of medications, to track 1) which pharmacies make errors and how often; 2) the nature of errors that are made (incorrect dosage of correct medication type, or dispensing of the wrong type of medication altogether), and to implement interventions that will reduce the rate of error to zero.

Indicators

Denominator: The number of prescription copies that are compared to computerized dispensing data (1000 to be examined) in our baseline sample period.

Numerator: The total number of dispensing errors found in the sample of 1000.

Baseline: A random sample of 1000 prescriptions during June, July, and August, 2005, from our Mesa and Phoenix outpatient clinics will be matched to PCN (Pharmacy Care Network) billing data. A similar sample of 1000 will be taken in June, July, and August, 2006, to measure the effect of our intervention. This PCN data is being used because it is the only medications database available to us. PCN data includes only non-Medi-Cal clients, but there is no reason to presume that the dispensing error rates for Medi-Cal and non-Medi-Cal clients are different. Once the baseline is established the study will continue on Medi-cal only clients.

Log of Voluntary Reports: We will continue to examine client self-reports of dispensing errors, and these will be tracked by the assigned nurse. The Phoenix Clinic nurse will log all dispensing errors reported by clients to clinic staff of any MHP site (which will also supply a copy of the prescription form to the nurse).

Goal: Reduce number of incidents of incorrect dispensing of medications to zero.

Indicator selection: Though more manpower intensive, the above indicator was preferred to a survey of clients since it will be more thorough and more representative. It was preferred to client voluntary self-report data since it will almost certainly show more errors than clients report.

Study Population

Randomly selected prescriptions given to non-Medi-Cal clients will be examined. It is presumed that there are no systematic differences between Medi-Cal and non-Medi-Cal clients or between clients in different regions of the County. (Non-Medi-Cal clients can go to their choice of any of the large number of PCN network pharmacies.) It is assumed that research results can be extended to all clients receiving medications.

Sampling Method

Random selection from PCN data

Data Collection Procedures

The data to be collected will be: 1) The number of errors in medications dispensed at pharmacies, 2) the number of the two types of errors possible, and 3) the pharmacies at which these errors occur.

For the self-report data, a tracking form has been developed by the MMC, and voluntarily-reported errors in dispensing medication from pharmacies will be recorded by the registered nurse at the Phoenix clinic. Each clinic will be responsible for forwarding the necessary information to the nurse at the Phoenix clinic, including a copy of the written prescription. To date, only anecdotal information exists regarding the problem of interest. For each error identified, the Director of Medical Services will continue to send letters to the pharmacy asking it to identify the reason for the error.

Improvement Strategies

The letters sent to pharmacies about each error have been serving and will serve as a deterrent in themselves.

If the problem proves to be substantial, then the reasons found will be addressed through specific interventions (human error by M.D. or pharmacy; illegible prescriptions; electronic data problems; etc.).

In October through December, 2005, clients will be educated via written material regarding the importance of checking medication received against the original prescription at the time it is received and will be asked to report all such errors to DBH staff. This should reduce the impact of errors that continue to be made.

Pharmacies making "unacceptable" levels of errors could be reported to the State Pharmacy Board, and clients can be informed that these pharmacies have greater numbers of dispensing errors.

Data Analysis and Interpretation of Study Results

Simple proportions and chi-square tests should suffice.

Determining if Improvement Achieved Is Real

Further three-month samples can be examined at later dates.

Determining if the Improvement Is Sustained

Depending on what improvement strategies are undertaken, it can be later tested whether improvement achieved is maintained after these strategies are terminated. It is expected that the monitoring of voluntarily reported dispensing errors would continue indefinitely.